STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN4708	A. BUILDING: _____ B. WING _____	C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTON HEALTH & REHABILITATION CENTER	3916 BOYDS BRIDGE PIKE KNOXVILLE, TN 37914

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments Investigation of complaints #50876, #51272, and #51282 was conducted on 6/15/2020-6/17/2020 at Holston Health & Rehabilitation Center. No deficiencies were cited in relation to the complaints under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		